

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155100</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/30/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARDEN VILLA - BEDFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 NORTON LN</b> <b>BEDFORD, IN 47421</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN0000148127 and IN00148386.</p> <p>Complaint IN00148127 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00148386 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: April 29 and April 30, 2014</p> <p>Facility number: 000040 Provider number: 155100 AIM number: 100274460</p> <p>Survey team: Susan Worsham, RN, TC Angela Patterson, RN (April 30,2014 only)</p> <p>Census bed type: SNF: 13 NF: 63 SNF/NF:56 Total: 132</p> <p>Census payor type: Medicare: 10 Medicaid: 110 Other: 12 Total: 132</p> <p>Sample:04</p> <p>Garden Villa - Bedford was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regards to the Investigation of Complaint IN00148127 and Complaint</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155100</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/30/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARDEN VILLA - BEDFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 NORTON LN</b> <b>BEDFORD, IN 47421</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 IN00148386.  Quality Review 05/01/14 by Lisa McColly	F 000			